MedStar Health

# MedStar Washington Hospital Center Medical Imaging School of Radiology
# Official Transcript Request Form

REQUEST FROM: (Name, Last 4 of SSN #, Year of Graduation and Address)

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**TRANSCRIPT REQUEST MUST BE SIGNED BY THE STUDENT**

I, _____, give MedStar Washington Hospital Center Medical Imaging School of Radiology permission to send ____ copies of my official transcript to the name and address identified below.

Thank you

_____ _____
Signature Date

WHERE TRANSCRIPTS SHOULD BE SENT **IF TRANSCRIPTS ARE BEING SENT TO THE STUDENT PLEASE PUT YOUR CONTACT INFORMATION HERE

(Name and Address)

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Submit your signed request to MWHCMedicalImagingSchoolofRadiology@medstar.net or fax to 202-877-8145